11.b. Occupational therapy services. (continued)

(15) Services provided by an independently enrolled occupational therapist who does not maintain an office at his or her own expense.

(16) For long-term care recipients, services for which there is not a statement every 30 days in the clinical record by the therapist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders hearing~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner or in the case of a resident of a long-term care facility on the written order of a physician as required by 42 CFR §483.45.

(2) Services provided by a speech language pathologist or a person completing the clinical fellowship year required for certification as a speech-language pathologist under the supervision of a speech-language pathologist.

(3) Services provided to a recipient whose functional status is expected by the physician or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period.

(4) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

(5) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Speech-language pathologist is defined as a person who has a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association and meets the state licensure and registration requirements for the services the person provides.

Coverage of **speech-language therapy services** does *not* include:

(1) Services that are not documented in the recipient's health care record.
(2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
(3) Services that are denied Medicare payment because of the provider's failure to comply with Medicare requirements.
(4) Services that are provided without written referral.
(5) Services not medically necessary.
(6) Services that are not part of the recipient's plan of care.
(7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
(8) Services provided by a speech-language pathologist other than the pathologist billing for the service, or a person completing the clinical fellowship year under the supervision of the pathologist, unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(9) Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.

Coverage of **hearing (audiology) therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner.
(2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.
(3) Services provided to a recipient who is expected to progress toward or achieve the objective specified in their plan of care within a 60-day period.
(4) Services provided under a written treatment plan which is reviewed at least once every 60 days, with certification and recertification by the ordering physician or physician assistant. If the service is provided to a Medicare beneficiary and covered by Medicare, the physician or physician delegate must review the plan of care and visit the patient at intervals required by Medicare rather than at intervals required by MA.
(5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. (This statement is not required for an initial evaluation).

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

Audiologist is defined as an individual who has a certificate of clinical competence from the American Speech-Language-Hearing Association.

Coverage of **hearing (audiology) therapy services** does *not* include:

(1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
(2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
(3) Services provided by an audiologist other than the audiologist billing for the services, or a person completing the clinical fellowship year under the supervision of the audiologist, unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

Hearing aid services: After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** is limited to:

(1) One monaural or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.
(2) Non-contract hearing aids require prior authorization.

Coverage of **hearing aids** does *not* include:

(1) Replacement batteries provided on a scheduled basis regardless of their actual need.
(2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
(3) Routine screening of individuals or groups for identification of hearing problems.
(4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
(5) Nonelectronic hearing aids, telephone amplifiers, vibrating molds, dry aid kits, and battery chargers.
(6) Maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
(7) Loaner hearing aid charges.
(8) Canal type hearing aids.
(9) A noncontract hearing aid that is obtained without prior authorization.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

(10) Services included in the dispensing fee when billed on a separate claim for payment.
(11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or a referral by the resident's family, guardian or attending physician.
(12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
(13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.

Augmentative and alternative communication devices are defined as devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include: communication picture books, communication charts and boards, and mechanical or electronic dedicated devices. Prior authorization must be obtained for all augmentative communication devices.

Coverage of **augmentative and alternative communication devices** is limited to:

(1) Evaluation for use of augmentative and alternative communication devices to supplement oral speech.
(2) Speech pathologists may only provide modification and programming of augmentative and alternative communication devices.
(3) Construction, programming or adaptation of augmentative and alternative communication devices.

11.c. ~~Services for individuals with~~ Speech, language, and hearing ~~and language disorders~~ therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Augmentative and alternative communication devices are not covered if facilitated communication is required.

12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See Items 12.a. through 12.d.

12.a. Prescribed drugs.

The following providers are eligible for payment for dispensing prescribed drugs:

(1) A pharmacy that is licensed by the Minnesota Board of Pharmacy.
(2) An out of state pharmacy that complies with the licensing and certification requirements of the state in which it is located.
(3) A physician located in a local trade area where there is no Medicaid enrolled pharmacy. To be eligible for payment, the physician shall personally dispense the prescribed drug according to applicable Minnesota Statutes and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.
(4) A physician or nurse practitioner employed by or under contract with a community health board, for the purposes of communicable disease control.

The following limitations apply to pharmacy services:

(1) With the exception noted below, the prescribed drug must be a drug or compounded prescription that is made by a manufacturer that has a rebate with the Health Care Financing Administration (HCFA) and included in the Minnesota Department of Human Services drug formulary. The formulary is established in accordance with §1927 of the Social Security Act. See Drug Formulary.

A prescribed drug is covered if it has Investigational New Drug (IND) status with an IND number by the United States Food and Drug Administration (FDA), even though the manufacturer does not have a rebate with HCFA. When the prescribed drug receives FDA approval, the manufacturer must have a rebate agreement for the drug in order for the drug to be covered.

(2) A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.